MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., Jul 99)

PROSTHETICS & ORTHOTICS

EST. LENGTH OF NEED (# OF MONTHS):_____ 1-99 (99=LIFETIME)

SECTION A (TO BE COMPLETED BY PHYSICIAN)

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH MEDICAID I.D. NUMBER:	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER MEDICAID PROVIDER NUMBER:

DIAGNOSIS:

PROGNOSIS:

FUNCTIONAL LIMITATIONS:

DATE OF LAST EVALUATION BY PHYSICIAN:	PHYSICIANS NAME:

SECTION B (CAN BE COMPLETED BY ORTHOTIST/PROSTHETIST)

1. Is this the initial prosthesis/orthotics? Y / N (If yes, skip to number 6)

2. Purchase date of last prosthesis/orthotics:

3. Name, phone number, and address of supplier:

4. List all modifications & growth adjustments made to this prosthesis/orthotics and dates of such:

5. Can current prosthesis/orthotics be reused in all or part to meet current needs? (Explain)

6. Narrative description of **ALL** items, accessories, sizes and options to be included on this prosthesis/orthotics: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services